Division of Medical Assistance	**Clinical Coverage Policy No.: 1F**
Chiropractic Services	**Original Effective Date: July 1, 1996**
	Revised Date:November 1, 2007

Table of Contents

1.0 Description of the Service

Chiropractic is defined to be the science of adjusting the cause of disease by realigning the spine, releasing pressure on nerves radiating from the spine to all parts of the body, and allowing the nerves to carry their full quota of health current (nerve energy) from the brain to all parts of the body. (G.S. 90-143)

1.1 Manipulation

A manual procedure that involves a directed thrust to move a joint past the physiological range of motion, without exceeding the anatomical limit.

1.2 Motion Segment

A functional unit made up of the two adjacent articulating surfaces and the connecting tissues binding them to each other.

1.3 Subluxation

For the purpose of Medicaid claims, subluxation is defined as a motion segment in which alignment, movement integrity, and/or physiological function are altered although contact between joint surfaces remains intact.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Medicaid for Pregnant Women

Pregnant women with Medicaid for Pregnant Women (MPW) benefits (pink MID card) are eligible for chiropractic services if the service is required for a pregnancy-related condition. Chiropractic services for these recipients must be prior approved (see **Section 5.1**).

2.3 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination****** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will

be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.
b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

***Basic Medicaid Billing Guide*:** http://www.ncdhhs.gov/dma/medbillcaguide.htm

EPSDT provider page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

3.0 When the Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

3.1 General Criteria

Medicaid covers manual manipulation of the spine when it is necessary to correct subluxation and

a. the procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;

b. the procedure can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

c. the procedure is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

Chiropractic services are limited to manual manipulation (use of hands) of the spine to correct a subluxation that has resulted in a musculoskeletal condition for which manipulation is appropriate [42 CFR 440.60(b); 10A NCAC 220.0106]. The service must relate to the diagnosis and treatment of a significant health problem in the form of a musculoskeletal condition necessitating manual manipulation.

Note: With the exception of X-rays (refer to **Section 5.3**), no other diagnostic or therapeutic service furnished by a chiropractor or under his or her order is a covered service.

3.3 Subluxation

Subluxation must be confirmed by physical examination and/or by one set of X-rays taken within 6 months of the initial date of service. To demonstrate a subluxation by physical examination, one or both of the following conditions must be documented:

a. Asymmetry or misalignment on a segmental or sectional level, **or**

b. Range of motion abnormality must be demonstrated.

If only one of these two conditions listed above is present, one of the following conditions must also be present:

a. Pain and/or tenderness evaluated in terms of location, quality, and intensity

b. Tissue or tone changes in the characteristics of contiguous or associated soft tissue including skin, fascia, muscle, and ligament.

4.0 When the Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

4.1 General Criteria

Chiropractic services are not covered when

a. the recipient does not meet the eligibility requirements listed in **Section 2.0;**
b. the recipient does not meet the necessity criteria listed in **Section 3.0;**
c. the procedure unnecessarily duplicates another provider's procedure; or
d. the procedure is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

Chiropractic services are not covered in any of the following conditions:

a. Maintenance programs, active corrective care, or supportive care, preventive care, or wellness care are not covered services:
    1. Maintenance programs, active corrective care and supportive care are therapies that are performed to treat a chronic, stable condition or to prevent deterioration. Once the maximum therapeutic benefit has been reached, chiropractic care is no longer considered necessary; therefore, maintenance and supportive care are not covered services.
    2. Active corrective care as ongoing treatment rendered after the patient has become symptomatically and objectively stable, to prevent a recurrence of the patient's condition, is not covered.
    3. Preventive care or wellness services such as nutritional supplements, hygienic modalities, environmental modalities, rehabilitation and physiotherapeutic modalities, massage therapy, counseling, patient education, home exercises, and ergonomic postural modification. Any program or treatment plan that is developed to prevent disease, promote health, prolong life, or enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a chronic condition, is not a covered service.
b. Diagnostic procedures and tests, including but not limited to the following, are not covered when furnished or ordered by a chiropractor:
    1. Laboratory tests
    2. X-rays, with the exception of the CPT X-ray procedure codes listed in **Attachment A**
    3. Videofluoroscopy
    4. ECGs
c. The following therapeutic modalities are not covered services when performed by a chiropractor:
    1. Physical and/or occupational therapy

        Note: Chiropractors may not seek reimbursement for physical or occupational therapy services performed under the supervision of a medical/osteopathic physician or as an attending provider when the billing provider is a medical or osteopathic physician. (Refer to Clinical Coverage Policy #10A, *Outpatient Specialized Therapies,* on DMA's Web site at http://www.ncdhhs.gov/dma/mp/mpindex.htm.)
    2. Traction (axial or longitudinal)
    3. Injections

4. Acupuncture
5. Mechanical or electrical equipment used for manipulations or other treatment modalities: mechanical or electrical equipment used for therapeutic manipulations or other treatment modalities that are not clearly related to symptoms and/or diagnostic X-rays, or that are not likely to result in long-term improvement of a recipient's symptoms or conditions, or that do not have a clearly defined and achievable end point

d. Nutritional supplements are not a covered service.

4.3 Spinal Manipulation

Spinal manipulation, also called manual manipulation of the spine, is not considered necessary for the following musculoskeletal conditions, including but not limited to

a. Rheumatoid arthritis
b. Muscular dystrophy
c. Multiple sclerosis
d. Idiopathic scoliosis or treatment of the curve progression in late adolescence or adulthood, unless there is another indication for chiropractic manipulation.

Spinal manipulation is not covered for non-musculoskeletal conditions, including but not limited to

a. Pneumonia
b. Emphysema
c. Sinus problems
d. Suppurative otitis media
e. Infectious diseases
f. As a substitute for childhood immunizations

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

5.1 Prior Approval for Recipients with Medicaid for Pregnant Women Benefits

Prior approval is required for chiropractic services for recipients with Medicaid for Pregnant Women (MPW) benefits. Prior approval must be obtained before a chiropractic service is rendered. A referral from the obstetrical provider must be submitted with the request for prior approval.

Refer to the *Basic Medicaid Billing Guide* on DMA's Web site at http://www.ncdhhs.gov/dma/medbillcaguide.htm for additional information on prior approval.

5.2 Treatment Plans

A clear and appropriate treatment plan must document the symptoms or diagnosis treated, diagnostic procedures and treatment modalities used, results of diagnostic procedures and treatments, and anticipated length of treatments.

5.2.1 Continued Treatment

a. If no improvement is documented within the initial two weeks of chiropractic care, the treatment plan must be modified and documented in the recipient's medical record.

b. If no improvement is documented after 30 days of modified chiropractic treatment, no additional treatment will be covered.

c. Once the maximum therapeutic benefit has been achieved, further chiropractic care is not covered.

d. A copy of the treatment plan must be maintained in the recipient's chiropractic record.

5.3 X-Rays

Medicaid covers X-rays as part of the documentation associated with the definition of the musculoskeletal condition for which manual manipulation of the spine is appropriate.

a. Medicaid covers one set of X-rays taken within six months of the date of service.

b. X-rays must be kept on file in the recipient's records for a period of 5 years.

Note: These records are subject to post-payment review.

Refer to **Attachment A** for the list of X-ray procedure codes that are covered.

6.0 Providers Eligible to Bill for the Procedure

Chiropractic providers must meet the educational requirements outlined in 42 CFR 410.21(a). Providers who meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program to provide chiropractic services are eligible to bill for chiropractic services. The chiropractor can bill only for services that are within the scope of practice of a chiropractor.

7.0 Additional Requirements

Inasmuch as chiropractors treat disease without the use of surgery or medications, it is expected that when the use of surgery or medication is indicated, the chiropractor shall refer the recipient to a medical or osteopathic physician.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 1996

Revision Information:

Date	Section Updated	Change
11/1/07	Section 3.3	Revised requirement to document necessity by X-ray to include physical examination
11/1/07	Attachment A, Item F	Corrected place of service

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports necessity. The level of the subluxation must be specified (using the appropriate ICD-9-CM code) and must be listed as the primary diagnosis. The musculoskeletal conditions and/or symptoms necessitating the treatment must be listed as the secondary diagnosis.

1. Primary ICD-9-CM Codes

739.0	Nonallopathic lesions, not elsewhere classified, head
739.1	Nonallopathic lesions, not elsewhere classified, cervical
739.2	Nonallopathic lesions, not elsewhere classified, thoracic
739.3	Nonallopathic lesions, not elsewhere classified, lumbar
739.4	Nonallopathic lesions, not elsewhere classified, sacral
739.5	Nonallopathic lesions, not elsewhere classified, pelvic
739.8	Nonallopathic lesions, not elsewhere classified, rib cage

2. Secondary ICD-9-CM Codes

307.81	Tension headache
346.0 through 346.9	Migraine
333.83	Spasmodic torticollis
353.1 through 353.9	Nerve root and plexus disorders
715.80 through 738.6	Diseases of the musculoskeletal system and connective tissue
784.0	Headache
846.0 through 847.9	Sprains and strains
905.0 through 905.9	Late effects of musculoskeletal and connective tissue injuries
907.3	Late effect of injury to nerve root(s), spinal plexus(es) and other nerves of the trunk

C. CPT Procedure Code(s)

1. Chiropractic Services

98940	Chiropractic manipulative treatment (CMT); spinal, 1–2 regions
98941	Chiropractic manipulative treatment (CMT); spinal, 3–4 regions
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions

2. X-rays

Chiropractors may use the following CPT X-ray codes to document the musculoskeletal condition for which manual manipulation of the spine is appropriate.

72010	72020	72040	72050	72052	72069	72070
72072	72074	72080	72100	72110	72114	72120
72170	72190	72200	72202	72220		

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

Manipulation of the spine may be billed only once per date of service.

F. Place of Service

Office

G. Co-Payments

Chiropractic visits have a co-payment of $2.00 per visit for recipients aged 21 years and older. Refer to the *Basic Medicaid Billing Guide* (on DMA's Web site at http://www.ncdhhs.gov/dma/medbillcaguide.htm) for information on exemptions to co-payment requirements.

H. Reimbursement Rate

Providers must bill their usual and customary charges.

Claims for dually eligible recipients must be filed as Medicaid claims and are subject to all Medicaid policies.